DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OTC 9/30/12

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #1	445242	A. BUILDING _____ B. WING _____	C 08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREYSTONE HEALTH CARE CENTER	181 DUNLAP ROAD, PO BOX 1133 BLOUNTVILLE, TN 37617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, observation, and interview the facility failed to accurately and completely document a resident's clinical condition for one resident (#4) of five sampled residents. The findings included: Review of facility policy dated October 15, 2011, revealed, "Hemodialysis...Documentation Guidelines The following information should be recorded on Dialysis Communication Record...List of medications administered in the prior six (6) hours...Original is sent with resident to Dialysis Center...Dialysis Center documents on bottom of form...Medications given during/after dialysis...Pre (before) & Post (after) treatment weights...vital signs...Special Instructions/Comments and/or changes in resident's condition..." Resident #4 was admitted to the facility on November 18, 2011, with diagnoses including End Stage Renal Disease. Medical record review of a physician's order dated February 12, 2012, revealed, "Alprazolam (Xanax) 1 mg (milligram) tablet...1 tablet orally every morning before dialysis every Mon	F 281	Please consider this plan of correction Greystone's Health Care Center's credible allegation of compliance under Federal Medicare and Medicaid requirements. Submission of this plan of correction is not an admission of that a deficiency exists or that the facility agrees they were cited correctly. This plan of correction reflects the desire to continually enhance the quality care and services provided to the residents and are submitted solely as a requirement of the provisions of Federal and state law. F281 **Resident # 4 medication orders were reviewed by the unit manager and the dialysis center on 8/16/2012.** **Unit managers reviewed medication administration records with charge nurses for accurate documentation of medications being administrated to residents prior to dialysis.**	8/29/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Turner — TITLE: Administrator — (X6) DATE: 8/30/2012

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1 (Monday), Wed (Wednesday), & Fri (Friday)." Medical record review of a Controlled Drug Record and a Medication Administration Record dated July 6, 2012, revealed Alprazolam 1 mg. was signed out at 5:00 a.m. and administered as ordered by the physician. Medical record review of a Dialysis Communication Form dated July 6, 2012, revealed the facility completed the top portion of the form and included, "...Medication(s) Given In The Six (6) Hours Prior to Sending the Patient for Dialysis Treatment: Ativan (Lorazepam) 1 mg..." Continued review revealed the bottom portion of the form was blank. Medical record review of a recapitulation (brief summary) of physician orders effective July 1, 2012, through July 31, 2012, revealed no documentation regarding a physician's order for Ativan. Medical record review of the MAR dated July 6, 2012, revealed no documentation regarding administration of Ativan. Medical record review of a nurse's note dated July 6, 2012, at 9:30 a.m., revealed, "Resident out to dialysis." Medical record review revealed the next nurse's note entry was dated July 7, 2012, and no documentation regarding the resident's condition on July 6, 2012, and/or confirmation the resident received dialysis on July 6, 2012. Observation on August 15, 2012, at 1:50 p.m., revealed the resident seated in a wheelchair and	F 281	**The facility unit managers will complete a weekly audit for 4 weeks then twice a month for 8 weeks on the completion of dialysis communication forms.** **On August 16-17, 2012 the staff development coordinator educated nurses on completing the dialysis communication form prior to dialysis.** **Results of the audits will be reviewed monthly by the QA&A Committee x 3 months, with changes to the plan or monitoring as deemed appropriate by the QA&A Committee.** **The DON, and Unit Managers will be responsible for overall compliance.**	

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F 281	Continued From page 2 was alert and oriented. Interview with the Director of Nursing on August 16, 2012, at 10:02 a.m., in the family room, revealed the nurse responsible for completion of the Dialysis Communication Form dated July 6, 2012, had incorrectly identified the medication administered to the resident prior to dialysis. Continued interview confirmed the facility's failure to accurately document medication administered to the patient on the Dialysis Communication Form and/or document the resident's condition on July 6, 2012, did not meet accepted standards of practice. C/O: #30109	F 281		

IN CASE OF EMERGENCY CONTACT INFORMATION

Employee Name:			
Address:			
Home Phone:		Cell Phone:	
Person(s) to be Notified:			
Name:		Relationship:	
Address:			
Home Phone:		Cell Phone:	
Name:		Relationship:	
Address:			
Home Phone:		Cell Phone:	
Physician(s):			
Name:			
Address:			
Phone:			
Name:			
Address:			
Phone:			
Blood Type:			
Name of Hospital Preferred:			
Drug Sensitivities and/or Allergies:			
Other information you feel would be important in an emergency:			

The above information will be kept confidential and will be stored in a secure place.